North Carolina Department of Health and Human Services

Beverly Eaves Perdue, Governor — Lanier M. Cansler, Secretary

Division of Mental Health, Developmental Disabilities and Substance Abuse Services
3001 Mail Service Center
Raleigh, North Carolina 27699-3001
Tel 919-733-7011• Fax 919-508-0951
Leza Wainwright, Director

Division of Medical Assistance
2501 Mail Service Center
Raleigh, North Carolina 27699-2501
Tel 919-855-4100 • Fax 919-733-6608
Craigan L. Gray, MD, MBA, JD, Director

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MEMORANDUM

TO:
Legislative Oversight Committee Members
Local CFAC Chairs
NC Council of Community Programs
County Managers
State Facility Directors
LME Board Chairs
Advocacy Organizations
MH/DD/SAS Stakeholder Organizations
Commission for MH/DD/SAS
State CFAC
NC Assoc. of County Commissioners
County Board Chairs
LME Directors
DHHS Division Directors
Provider Organizations
NC Assoc. of County DSS Directors

FROM:
Dr. Craigan L. Gray
Leza Wainwright

SUBJECT:
Implementation Update #56
Revised Effective Date for ACTT Service
Prospective Request = Initial Request
Update to "Incident To" by Provisionally Licensed
New Email and Mail Address for NEA Letters
CSC Assumes DMA Provider Enrollment
CAP-MR/DD Update: Psychological Evaluations
Revision to Guidance on CS QP% Calculation
Clarification of Licensed Professional Language
EPSDT Request

Revised Effective Date for Assertive Community Treatment Team (ACTT) Service

The effective date for the following rate decrease that was published in Implementation Update #49 has been changed from January 1, 2009 to July 1, 2009.

Service Code	Service Description	Service Unit	Current Rate	New Rate
H0040	Assertive Community Treatment Team	per event, maximum 4 per month	$323.98	$301.35

Fee schedules are available on the Division of Medical Assistance (DMA) website at http://www.ncdhhs.gov/dma/fee/. Providers must always bill their usual and customary charges.

Prospective Request = Initial Request on the Inpatient Treatment Report (ITR) Request Form

Check the "prospective" box on the Inpatient Treatment Report (ITR) form for initial requests only.

ValueOptions is receiving a number of concurrent requests for which the prospective box is checked in error by the provider. ITRs for adult requests marked as prospective that lack a new physician signature on the Person Centered Plan

(PCP) are returned as "Unable to Process." When this occurs for a request that was actually a concurrent request, depending on the timing between the original incorrect request and the start date, it may result in a concurrent request with a delayed start date and a gap in authorization periods.

From the ITR Instructions document on the valueoptions.com web site:

- Prospective: check this if the consumer has never received this level of care from your agency.
- Concurrent: check this if the consumer is currently receiving this level of care from your agency.

Update: Behavioral Health Services Provided by Provisionally Licensed Professionals in Physician Offices
The March 2009 Medicaid Bulletin provides full information on Behavioral Health Services Provided by Provisionally Licensed Professionals in Physician Offices. Specific to the prior approval guidelines pertaining to the SC modifier, the prior approval guidelines in the May 2009 Medicaid Bulletin supersede the prior approval guidelines pertaining to the SC modifier in the March 2009 Medicaid Bulletin.

Prior Approval
Agencies that have received prior approval from ValueOptions for dates of service July 1, 2008 to May 1, 2009 for the H0001, H0004, H0005, and H0031 will not be required to request a new prior approval using CPT codes for dates of service provided prior to May 1, 2009.

The March 2009 Medicaid Bulletin directed providers to submit new requests for prior authorization for dates of service effective May 1, 2009 and forward using CPT codes and the SC modifier. In order to make the process more streamlined for providers, this requirement has been modified. Providers are required to submit a new request for prior approval to ValueOptions using CPT codes for service dates effective May 1, 2009 and forward. However, providers should **not** include the SC modifier on the service request form.

Providers may submit one authorization request per recipient for services provided by both the physician and the provisionally licensed professional.

NOTE: For dates of services May 1, 2009 and forward, providers must bill for services provided by provisionally licensed professionals "incident to" the physician using the CPT codes with the SC modifier as specified in the March 2009 Medicaid Bulletin.

Notification of Endorsement Action (NEA) Must be Emailed and Mailed to a New Address
Computer Sciences Corporation (CSC) assumed Medicaid provider enrollment activities effective April 20, 2009. The endorsing agency must now submit NEA letters to CSC via certified mail to:
N.C. Medicaid Provider Enrollment, CSC
2610 Wycliff Road, Suite 102
Raleigh, NC 27607
or electronically to endorsement.dma@lists.ncmail.net.

The endorsing agency shall continue to copy the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) at: endorsements.accountability@ncmail.net.

CSC Assumes N.C. Medicaid Provider Enrollment, Credentialing, and Verification Activities
Please visit http://www.ncdhhs.gov/dma/provider/mmis.htm for updated information concerning N.C. Medicaid provider enrollment, credentialing, and verification activities.

CAP-MR/DD Update: Requirement for Psychological Evaluations
Implementation Update # 55 indicated, "A current psychological evaluation that assesses both cognitive and adaptive functioning must accompany each initial plan. The psychological evaluation must have been completed within the last three years for persons 18 and older or within one year for children less than 18. For evaluations that are beyond these time frames, a licensed psychologist or licensed psychological associate may attach a concurrence to the full psychological evaluation stating that the evaluation is still valid." To clarify for Continued Need Reviews (CNRs), after the initial plan, the psychological evaluation does not have to be completed or updated unless the participant has experienced changes that warrant an updated evaluation.

Please refer to the link below for **CAP-MR/DD Update 4-21-09** which addresses information specific to; *Case Management Request for Technical Assistance from Value Options*, *Services Delivered in Staff Member Homes*, and *Requirements for Behavior Support Plans*: http://www.ncdhhs.gov/mhddsas/cap-mrdd/cap-update4-21-09.pdf.

Revision to Guidance on Calculating the Community Support Qualified Professional Standard

There has been confusion about some of the dates and percentages contained in the original iteration of these directions for calculation of the Community Support qualified professional standard. Please note the changes (additions or deletions) below. Additions are in bold, while deletions are shown with a strikethrough to ensure notice of the revisions.

Beginning March 1, 2009, the state plan amendment (SPA) requires that Community Support providers meet a 35% qualified professional (QP) service measure, and then in September 2009, a 50% service measure, up from the 25% benchmark that has been in place. There are two measurements for LMEs to utilize to determine compliance:

1. Monthly reports that indicate the provider meets the 35%/50% benchmarks.
2. Three month aggregates to indicate that the average over three months meets the appropriate benchmark.

In order to facilitate the transition from 25% to 35% to 50%, while maintaining the integrity of the SPA requirements, and also to recognize the lag between service dates and paid claims dates, the following direction is provided. **Please note that in #1 below, the first column is the month billing took place, the second column is the month an LME review is completed and report calculated for the billing month. The third column indicates the service measure percentage required during the month of billing. For example the April 2009 LME review date indicates the required standard to be reported for the billing month of March 2009 is 35%.**

In #4 below, the aggregate report dates are indicated in the "Months of Billing" column. The second column is the month a review is completed and report submitted for the 3-month period. The third column indicates the required standard needed for those three months. For example the March, April, May 2009 aggregate dates require a 35% standard to be reported. The report for that period will be submitted in June 2009.

1. Individual monthly reports will need to meet the requirements below:

Month of Billing	Month of LME Review	QP %
December 2008	January 2009	25%
January 2009	February	25%
February	March	25%
March	**April**	**35%**
April	May	35%
May	June	35%
June	July	35%
July	August	35%
August	September	35%
September	**October**	**50%**
October	November	50%
November	December	50%
Ongoing	*Ongoing*	50%

2. For the **LME review** months of ~~March,~~ April, May **and June 2009**, if any individual monthly report does not indicate 35%, a Plan of Correction will be issued by the LME.
3. For the **LME review** months of ~~September,~~ October, November **and December 2009**, if any individual monthly report does not indicate 50%, a Plan of Correction will be issued by the LME.
4. Aggregate reports for the following months, and the associated percentages must also be met:

Months of Billing	Month of LME Review	Aggregate QP %
December 2008, January, February 2009	March 2009	25%
January, February, March 2009	April	25%
February, March, April 2009	May	25%
March, April, May 2009	**June**	**35%**
April, May, June 2009	July	35%
May, June, July 2009	August	35%
June, July, August 2009	September	35%
July, August, September 2009	October	35%
August, September, October 2009	November	35%
September, October, November 2009	**December**	**50%**
October, November, December 2009	January 2010	50%
Ongoing	*Ongoing*	50%

5. Beginning with the three month period of **March**, April, May~~, June~~ 2009, if any aggregate report does not indicate meeting the 35% benchmark, endorsement will be withdrawn.
6. Beginning with the three month period of **September**, October, November~~, December~~ 2009, if any aggregate report does not indicate meeting the 50% benchmark, endorsement will be withdrawn.

Clarification of Licensed Professional Language in DMA Clinical Policy 8A

The January 1, 2009 revision of the Division of Medical Assistance Clinical Coverage Policy 8A, Section 6.1 General Information, reads "The agency must have a full-time licensed clinical professional on staff." This statement was included in the policy in error and applies only to Community Support agencies at this time.

However, as the current enhanced mental health and substance abuse service definitions are reviewed and approved, it is the intention of the Division of Medical Assistance and the Division of Mental Health, Developmental Disabilities and Substance Abuse Services to require agencies providing clinical services to employ a full-time licensed professional as appropriate.

EPSDT Request

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) is the federal law that says Medicaid must provide all medically necessary health care services to Medicaid-eligible children. The services are required even if the services are not normally covered by children's Medicaid. Providers are responsible for ensuring that staff and recipients are aware of EPSDT. Please refer to the DMA web site for the EPSDT policy, forms and training materials: http://www.ncdhhs.gov/dma/epsdt/index.htm.

Unless noted otherwise, please email any questions related to this Implementation Update to ContactDMH@ncmail.net.

cc: Secretary Lanier M. Cansler
Allen Feezor
Dan Stewart
DMH/DD/SAS Executive Leadership Team
DMA Deputy and Assistant Directors
Christina Carter
Sharnese Ransome
Wayne Williams
Shawn Parker
Melanie Bush